Alberta Health Services

Lois Hole Hospital for Women

Patient Label

Allard Hereditary Breast and Ovarian Clinic

Referral Form

Fax to: (780) 735-5611 / Clinic number: (780) 735-4718

Date of Referral: ________________________________

Patient Information:

Name:____________________________________ PHN:________________________

Address:__________________________________ Home #:______________________

City: ____________________________________ Postal Code:___________________

Work #______________ Cell# ______________________ Birth date (dd/mm/yyyy):_____________

Referral to: Breast Specialist ☐ GyneOncology ☐ Both Breast and GyneOncology ☐

Note Incomplete Referrals will be sent back to the referring provider

The following referral criteria **MUST** be met:

Referral Criteria: *PLEASE CHECK ALL THAT APPLY*

- ☐ Patients age **25 to 70** and have not had bilateral mastectomies (exception GyneOncology only referral)
- ☐ Patients who are **recommended** for follow up by a **Genetics Clinic** (with > 20% lifetime risk)
- ☐ Patients who have a mutation to **BRCA1 or 2** (please include documentation from Genetics Clinic)
- ☐ **First degree relative** of patients who have a documented **mutation of BRCA1 or BRCA2**
- ☐ Family members of patients in the clinic who have a recommendation by HBOC clinicians
- ☐ Women with history of **radiation treatments to the thorax** before the age of 30
- ☐ **Strong family history of breast and/or ovarian cancer**
  - ☐ 2 family members with breast cancer if:
    - ☐ One has been diagnosed with bilateral breast cancers
    - ☐ One is male
    - ☐ Both individuals were diagnosed with breast cancer **under the age of 50**
  - ☐ 3 family members with breast cancer one of whom is **under the age of 50** (this may span 2 generations)
  - ☐ 4 family members with breast cancer

NOTE: Family members should be blood relations to each other and the referred patient

Please include history including any previous cancers and where they were treated:________________________

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Date of last imaging (Mammogram, U/S, MRI) ____________________________ please include copy of reports.

Current or Previous Breast Concerns:____

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Referred by:

Name: ____________________________________ PRACID: ______________________________

Address: ____

City: ______________________________ Postal Code: _______________________________

Office Phone:_______________________ Fax Number: _______________________________